3100 Non-Medical Home and Community Based Services System (NMHCBS)

3101 Overview

The Non-Medical Home and Community Based Services System is designed to establish the necessary support services to retain functionally impaired individuals within their community and avoid premature institutionalization. Minimum standards associated with the various services identified within a Non-Medical Home and Community Based System must be met by the Area Agency on Aging within its Planning and Service Area.

This section provides an outline of the Aging and Adult Administration policies and procedures for the Non-Medical Home and Community Based Service System. **This policy chapter is subject to change as additional information and/or regulations are received from the U.S. Department of Health and Human Services, Administration on Aging.**

Reference: Older Americans Act of 1965, as Amended in 2000, P.L. 106-501, §102, §306, §307, §308 §321 and §339; Title 45 C.F.R. §1321.63; and A.R.S. Title 46 Chapter 1, Article 8, §46-191 and §46-192.

3102 Operational Principles

3102.1 The Non-Medical Home and Community Based Services System has the following goals:

A) To assist functionally impaired individuals to care for themselves in their home and community.

B) To prevent or delay less desired and more costly institutional placement.

C) To maintain the dignity, autonomy and independence of individuals and their families.

3103 Operational Procedures

3103.1 The Non-Medical Home and Community Based Services System includes, but is not limited to the following services:

A) Adult Day Care/Adult Day Health Care

B) Case Management

C) Housekeeper/Chore Services

D) Home Health Aid

E) Personal Care

F) Respite and Supportive Services for families and caregivers

G) Nursing (may also be referred to as Visiting Nurse Services or Home Nursing)

H) Minor Home Repair and Adaptation

I) Home Delivered Meals

J) Adaptive Aids and Devices, dependent upon available funding.

K) Other services as defined by Federal and State requirements.

3110 NMHCBS Eligibility Requirements

3111 Overview

The Aging and Adult Administration shall provide Non-Medical Home and Community Based Services to at-risk older, frail or disabled adults in an effort to delay or prevent the institutionalization of older and disabled adults, and to enable them to maximize their ability to continue to live in the environment of their choice.

This section provides an outline of the Aging and Adult Administration operational principles and procedures for the Non-Medical Home and Community Based Services System Eligibility Requirements. **This policy chapter is subject to change as additional information and/or regulations are received from the U.S. Department of Health and Human Services, Administration on Aging.**

Reference: Older Americans Act of 1965, as Amended in 2000, P.L. 106-501, §102 §306, §307 §308, §321 and §339; P.L. 92.603, §1602 (a)(10)(b)(1,2,3) of the Social Security Act; A.R.S. §46-251, §46-252, §46-253 and §46-192; and the Arizona Taxonomy 2003.

3112 Operational Principles

3112.1 The Non-Medical Home and Community Based Service System is a care managed system where case managers determine eligibility and need, authorize services, arrange for the provision of services, and monitor the services.

3112.2 The Supplemental Payments Program had been considered an entitlement program for Aging and Adult Administration clients eligible for Housekeeper, Home Health Aid and/or Visiting Nurse services until June 30, 1993. It is now a discretionary program, based upon funding availability.

3113 Operational Procedures

3113.1 The following individuals are eligible to receive Non-Medical Home and Community Services (NMHCBS):

A) Individuals 60 years of age or older.

B) Individuals under 60 years of age with a disability.

C) Family Caregivers as defined in the Aging and Adult Administration Policy and Procedures Manual Chapter 3600 – Family Caregiver Support Program.

3113.2 The following eligibility criteria apply to NMHCBS. Individuals shall be assessed for Non-Medical Home and Community Based Services eligibility as defined in Chapter 3120 – Case Management for NMHCBS. See also Exhibit 3000A – Service Eligibility Matrix.

A) Individuals must be assessed as moderately to severely impaired in two areas of Activities of Daily Living or two areas of Instrumental Activities of Daily Living in order to be eligible for the following services: Adult Day Care/Adult Day Health Care; Personal Care; In-Home Respite/Group Respite; Minor Home Repair and Adaptation, Adaptive Aids and Devices,

and Supplemental Payments Program services. Other eligibility criteria apply for Supplemental Payments Program services as described in section 3113.2.B and C.

B) Individuals assessed as moderately to severely impaired in one Activity of Daily Living and one Instrumental Activity of Daily Living is not eligible to receive the services identified in section 3113.1.A.

C) Home health aid and home nursing are medically related services within the NMHBCS System. The following eligibility criteria apply:

1) Documentation of medical need from a health care practitioner of one of the following: insulin set-up, medication set-up, vital monitoring, nursing assessment, teaching by nurse, medication management/ monitoring, wound care, and catheter/colostomy care.

2) Documentation that the individual has no other resources available for obtaining the needed care, for example, the individual resides alone or the spouse or caregiver of the individual is incapacitated and unable to assist the individual with the medically related function.

3) Individuals must be assessed as moderately to severely impaired, in two areas of the Activities of Daily Living or medical need is identified as described in section 3124.2.A.2.

D) Individuals must be assessed as moderately to severely impaired in two areas of Instrumental Activities of Daily Living in order to be eligible for Housekeeping services and Home Delivered Meals. For Housekeeping services, one of the Instrumental Activities of Daily Living must be shopping, laundry, or housework. For Home Delivered Meals, one of the Instrumental Activities of Daily Living must be meal preparation. Other eligibility criteria apply for Home Delivered Meals as described in 3113.3.A.

3113.3 Operational Procedure 3113.1 does not apply to other Non-Medical Home and Community Based Services that have specific eligibility tests, as follows:

A) Home Delivered Meals as described in section 3203.2 of the Aging and Adult Administration Policy and Procedures Manual Chapter 3200-Nutrition Programs.

B) State Supplemental Payments Program (Housekeeping Services)

1) Individuals must meet the following criteria to be eligible for Housekeeping Services under the Supplemental Payments Program:

a) Must be a recipient of Supplemental Security Income (SSI) benefits.

b) Must be a resident of the State of Arizona.

c) Must be 18 years of age and older.

2) Individuals who were enrolled in the Supplemental Payments Program **prior** to June 30, 1993 were authorized to maintain a $70 monthly payment to purchase Housekeeping Services. This is also known as the Supplemental Payments Program Direct Pay.

a) The continuation of the $70.00 monthly payment is contingent upon the individual being impaired in one of the following three Instrumental Activities of Daily Living:

i) Shopping

ii) Laundry

iii) Housework

3) Individuals who were enrolled in the Supplemental Payments Program **after** June 30, 1993 are authorized to receive Housekeeping Services.

C) State Supplemental Payments Program (Home Health Aid and Visiting Nurse Services)

1) Individuals must meet the following criteria to be eligible for Home Health Aid and/or Visiting Nurse services under the Supplemental Payments Program.

a) Be a recipient of SSI benefits

b) Be a resident of the State of Arizona

c) Be 65 years of age or older.

d) Be moderately to severely impaired in two Activities of Daily Living or documentation for medical need must be provided.

D) Family Caregiver Support Program Services

1) Refer to Aging and Adult Administration Policy and Procedure Manual, Chapter 3600 – Family Caregiver Support Program.

EXHIBIT:
3000A – Service Eligibility Matrix

3120 Case Management for NMHCBS

3121 Overview

Case management is provided to any individual entering the Non-Medical Home and Community Based Service System (NMHCBS). Case management is a service provided by experienced or trained case managers to an older, frail and/or disabled individual, at the direction of the individual, family member, or caregiver. For the individual eligible for case management services, appropriate services and/or benefits are identified and comprehensively assessed, planned and coordinated with formal and informal resources, obtained and provided, recorded and monitored, modified, or terminated with follow-up provided where and when appropriate. The Area Agency on Aging, or entity that such agency has contracted with, is required to maintain a comprehensive case management system wherein an older, frail and/or disabled adult is determined eligible to receive services from the Non-Medical Home and Community Based Services System within the Planning and Service Areas.

This chapter provides an outline of the Aging and Adult Administration operational principles and procedures for case management. **This policy chapter is subject to change as additional information and/or regulations are received from the U.S. Department of Health and Human Services, Administration on Aging.**

Reference: Older Americans Act of 1965, as Amended in 2000, P.L. 106-501, §102, §306, §307 and§339, A.R.S. §46-191 and §46-192, and the Arizona Taxonomy.

3122 Operational Principles

3122.1 Area Agencies on Aging shall facilitate the coordination of community-based long-term care services designed to enable older, frail and/or disabled individuals to remain in their home by means that include one or all of the following:

A) Development of Case Management Services as a component of the long-term care services, as defined in section 3122.2.

B) Involvement of the long-term care providers in the coordination of such services.

3122.2 The Area Agency on Aging shall ensure that case management services be provided through the following:

A) Public or non-profit agencies that:

1 Give each individual seeking services a list of agencies that provide similar services within the jurisdiction of the Planning and Service Area.

2 Give each individual the right to make an independent choice of service providers and document the receipt by such individual of such a statement.

3 Ensures case managers act as agents for an individual receiving the services and not as promoters for the agency providing services.

B) The Area Agency on Aging may provide case management services directly if approval was granted by the Aging and Adult Administration through the direct services waiver, as described in Chapter 2100 – Area Plan on Aging.

3122.3 Case management shall be an integrated system that accomplishes the following:

A) Provides access to the Non-Medical Home and Community Based Service System through a single point of entry utilizing approved eligibility assessment instruments.

B) Applies a client-centered approach in determining needed services.

C) Allows for a problem-solving orientation that uses a holistic assessment of the client's situation and mechanism that addresses the problems contributing to the client's situation.

D) Promotes networking to ensure the coordination of service and development of a cost-effective service plan.

3122.4 In providing case management, the Area Agency on Aging, or entity that such agency has contracted with, shall comply with the following:

A) Not duplicate case management services provided through other Federal and State programs, such as the Arizona Long-term Care System (ALTCS); the Arizona Department of Economic Security, Division of Developmental Disabilities (ADES, DDD); and the Arizona Department of Health Services (ADHS). Efforts shall be made, to the extent possible, to ensure that coordination with other service systems do not result in services being duplicated and that the client's goals and objectives are not compromised between service systems.

B) Conduct a functional assessment of all clients entering the Non-Medical Home and Community Based Service System to determine eligibility.

3122.5 The Area Agency on Aging shall ensure case management providers receive the appropriate orientation and training on case management policies and procedures.

3123 Operational Procedures for Assessing Eligibility

3123.1 The Area Agencies on Aging shall be the single point of entry into the Non-Medical Home and Community Based Service System.

3123.2 Individuals shall be assessed for eligibility within **seven** business days after the referral has been screened and accepted.

3123.3 Eligibility for entry into the NMHCBS System requires the use of one of the following assessment instruments:

A) The Arizona Standardized Client Assessment Plan (ASCAP), as defined in section 3123.4.

B) The Short Form Intake Document (SFID – formerly known as the Short Term Form or STF), as defined in section 3123.5.

3123.4 The ASCAP is the recommended assessment instrument for the individual and the case manager to be used on individuals requiring assistance, except as defined in section 3123.5.

A) A home visit is required for all individuals assessed with the ASCAP.

B) The ASCAP shall be used to determine eligibility for the following services:

1) Adult Day Care/Adult Day Health Care

2) Housekeeping (includes chore and shopping)

3) Personal Care

4) Home Delivered Meals

5) Home Health Aid

6) Home Nursing

7) Respite (in home and group)

C) The case management provider shall conduct a re-determination of eligibility every twelve months, or more frequently, as appropriate.

3123.5 The SFID is generally used when services are needed for a period less than 90 days or for caregiver support services as described in 3123.5 B. **If Non-Medical Home and Community Based Services were authorized through the ASCAP, the SFID shall not be used.**

A) A home visit is not required when using the SFID to assess individuals for eligibility, except for services described in 3123.5.B.3.a.

B) The SFID may be used to determine eligibility for the following services:

1) One Time Case Management

2) Short Term Home Delivered Meals, *if Home Delivered Meals is the only service being authorized.* If the applicant is determined eligible for home delivered meals and the spouse meets the requirements as described in 3203.2.B, Long Term Home Delivered Meals for the spouse may be authorized.

3) Family Caregiver Support Services

a) In-Home or Group Respite (This does not include emergency respite.)

b) Supplemental Services

3123.6 Qualifiers may also be used in determining eligibility as outlined in the Aging and Adult Administration Arizona Standardized Client Assessment Plan Manual.

3123.7 Services may be denied to individuals if one of the following are met:

a. The criteria described in section 3113 are not met.

b. With the exception of disclosing information on income, information necessary to complete an assessment is not provided.

3124 Operational Procedures for Service Authorization

3124.1 Services may be authorized to individuals meeting the eligibility criteria described in 3113.

3124.2 Services should be authorized based on the following priorities in descending order:

A) Individuals 60 years of age or older with greatest social and economic need with particular attention to older individuals who are low-income minority, older individuals residing in rural areas, older individuals with severe disabilities, older individuals with limited English speaking abilities, and older individuals with Alzheimer's disease or related dementias.

B) Individuals under 60 years of age who are disabled.

C) Eligible individuals accepted in an entitlement program or receiving services through another service system.

3124.3 Services are authorized using the assessment instruments described in 3123.3. **A correlation must be demonstrated between the individual's impairment level(s) and the service(s) authorized.**

A) The ASCAP is the primary assessment instrument used to authorize services.

1) The ASCAP shall be used to authorize the services described in 3123.4.B.

2) If individuals do not meet the criteria for medically related services identified in 3113.2.C.3, but are determined to be in need of a medically related service, authorization may be provided if the following is documented: At least one of the eight applicable choices in Category 9 of the Medical/Nursing Services is marked.

B) The SFID is <u>generally</u> used to authorize services for a period less than 90 days or for caregiver service authorization as described in 3123.5.B.

3124.4 Area Agencies on Aging may identify and authorize non-case management providers within their Planning and Service Area to complete and submit the SFID for an individual requiring short-term intervention. A non-case management provider may only authorize Short Term Home Delivered Meals.

3124.5 Tribal Area Agencies on Aging who do not have a case management system for aging services in their Planning and Service Areas may use the SFID to authorize services.

3124.6 Service authorizations, whether authorized with the ASCAP or SFID shall not exceed a 12-month period. The following applies when the authorization is provided using the SFID:

A) In-Home or Group Respite Services may be authorized for a 12-month period and must comply with section 3123.5.B.3.a.

B) Authorizations for Home Delivered Meals for the spouse shall coincide with the authorization of Home Delivered Meals for the primary recipient. *The SFID must cross reference the corresponding social security number of the primary recipient in order for the spouse's authorization to be valid.*

3124.7 Service Authorizations shall not exceed the levels required to meet the eligible individual's needs. The services authorized for an individual shall not deviate more than 25% from the actual levels that can be provided on a monthly basis. *Service authorizations may incorporate the "fifth week factor". The use of this factor is limited to those months that have a fifth week, with services being provided every week of the month. The "fifth week" factor shall not be used as a general business practice in service plan development.*

3124.8 The case management provider shall complete all mandatory fields on the assessment tools and obtain the necessary signatures and comply with the following time-frames:

A) The assessment tool shall be submitted to the Area Agencies on Aging for input into the Aging Information Management System (AIMS) within **seven** business days following the completion of the assessment.

B) Service plans must be forwarded to the service providers within **five** business days of authorization.

C) Service provision by the providing agency can commence before receipt of the service plan, but initiation is limited to **five** days before receipt of the plan.

D) Service providers shall initiate service provision authorized by the ASCAP and SFID within **seven** business days after an individual has been assessed for eligibility for the service(s) developed in the service plan.

3124.9 The Area Agency on Aging shall ensure data from the ASCAP and SFID is entered into the Aging Information Management System within **ten** business days after receipt of the ASCAP or SFID. If the ASCAP or SFID contains blank mandatory fields**,** the Area Agency on Aging must establish a process with their case management provider for completion of blank mandatory fields. **Documentation must exist that the case management provider supplied information for completion.**

3125 Operational Procedures for Case File Documentation

3125.1 The Area Agency on Aging shall ensure that their case management provider completes case files on each individual referred for case management.

3125.2 Case files must be maintained in accordance with the requirements for confidentiality outlined in the Aging and Adult Administration Policy and Procedures Manual Chapter 1900.

3125.3 Case files must contain the following documentation:

A) A copy of the annual assessment/reassessment instrument.

B) Case notes, through regular narrative entries, about the individual and his/her services based on contacts with providers, significant others, and the individual. Case notes should address the current functional status of the individual and identify linkages between the service plan goals, and the services selected and authorized for the client.

C) Copies of the referral forms utilized by case management agencies assigning the individual to a service provider.

D) Quarterly review and update of the individual's service plan.

3126 Operational Procedures for Monitoring of Service Plans

3126.1 The Area Agency on Aging shall ensure that their case management provider monitors service plans for individuals authorized to receive services **every 90 days** and shall be accomplished through a home visit unless otherwise specified:

A) Monitoring of the service plan is required to determine the following:

1) That the services authorized meet the individual's needs.

2) That services are being provided in accordance with the service plan.

3) The quality of the services provided.

4) That issues or problems relative to the service delivery process are identified.

5) That a course of action for identified issues or problems are developed.

B) Monitoring of service plans may be accomplished through the following approaches:

1) A telephone contact.

2) Inter-agency monthly or 90-day case conferences held with the service provider to discuss the service plan, service delivery issues, and/or problems encountered with the individual.

3) A home visit. A home visit is required **every 180 days**.

3126.2 Monitoring of service plans may result in revisions made to the service plan, based upon individual need(s). Revisions may include service continuation, modification or termination.

A) The following applies to services authorized through the ASCAP:

1) Home visits are required when service additions or deletions are made to the individual's service plan.

a) The case management provider shall obtain the necessary signatures for services added to or deleted from the service plan. *Signatures are not required for service level increases or decreases.* The ASCAP shall be submitted to the Area Agency on Aging based on the time frames identified in section 3124.7.

2) Services must be re-determined every 12 months. Home visits are required for services when conducting a re-determination.

3) Services may be terminated for some of the following reasons: voluntarily by the individual, the individual dies, the individual moves out of the planning and service area or the state, the individual is accepted by the Arizona Long Term Care System, the individual is admitted to an institution for an indefinite stay, or the individual becomes a resident of a long-term care facility. Termination of services within the service plan or case closures must be forwarded by the case management provider to provider agencies and the Area Agency on Aging within **seven** business days after the individual's case is closed. *Signatures are not required for termination of all services within the service plan.*

   a) When the reason for service termination is the individual's death, the case management provider must end date the service authorization(s) with the actual date of death.

   b) Voluntary service termination may occur when the individual and the case management provider agree that the service needs of the individual have been met. Documentation in the case file must support the voluntary termination.

   c) Services may also be terminated if the individual has not cooperated with the delivery of service. The lack of cooperation must be documented with specificity. Documentation in the case file must demonstrate attempts at resolution and subsequent service termination.

B) The following applies to services authorized through the SFID:

1) The individual shall be contacted by the case management provider at least **ten** business days **before** the end of the 90 day period to determine service continuance or termination. If service continuance is not warranted, the case management provider shall submit the SFID to the Area Agency on Aging within **seven** business days following the end of the 90 day period so that the services to that individual may be closed in AIMS.

2) If the SFID was used to authorize **Respite** only, monitoring of the service plan must be made every 90 days to assess the older individual. If during the monitoring, it is determined that only respite service is needed, then the SFID may be used to continue the respite service with the understanding that service plan monitoring is to occur every 90 days. If, during the service plan monitoring, it is determined that other services are needed, an ASCAP must be completed.

3127 Operational Procedures for NMHCBS Reporting Requirements

3127.1 The Area Agency on Aging shall collect data and maintain records relating to the Non-Medical Home and Community Based Services System as defined in the Aging and Adult Administration Policy Chapter 1600.